EnVision Independence Rehab Services

Off-Road Drivers Assessment
Occupational Therapy
Referral Form

Patient Information:

Patient Name: _____
Phone Number: _____
Date of Birth: _____
Medical Diagnosis: _____
_____

Patient Address:
_____
_____
ICD-10 Codes:
_____

REASON FOR REFERRAL (MARK ALL THAT APPLY):

- ☐ Decline in Cognition
- ☐ Change in Medical Condition
- ☐ Decline in Balance/Motor skills
- ☐ Medication Contraindications
- ☐ Recent Motor Vehicle Accident
- ☐ Visual/Perceptual Decline
- ☐ Psychological Changes
- ☐ Other_____

Therapy Services Recommended:

_X_ Occupational Therapy Evaluation and Treatment to Assess Drivers Safety

Physician Name: _____**Date:** _____

Physicians Signature: _____**NPI:** _____

Phone Number: _____ **Fax Number:** _____

PLEASE SEND THE FOLLOWING WITH THIS REFERRAL TO:
FAX: 724-320-0922

- **Patients Insurance Cards**
- **Last Visit Note Regarding Driving Concerns**

Phone: 724-900-4633
Fax: 724-320-0922
Email: Info@EnVisionIndependence.com
EnVisionIndependence.com